

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01142

01130

1. PLACE OF DEATH & COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
SOMERSET MARYLAND		a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EDW. W. McCREADY MEMO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA		4. DATE OF DEATH ADAMS JANUARY 29 1962	
First Last		Month Day Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 14, 1879	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME REVEL T. LEWIS		14. MOTHER'S MAIDEN NAME ANNA COLLINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MAUDE ADAMS, CRISFIELD, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 155.8		Obstruction, bowel - 5-7 days -	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Obstruction lesion, large bowel 3 -	
{ (c)		Carcinoma bowel 2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-22-62 , 19....., that (I) (we) last saw the deceased alive on 1-22-62 , 19....., and that death occurred at 10:45 AM , 19 1-29-62 , 19....., M, from the causes and on the date stated above.			
22e. SIGNATURE C. G. Rawley		M.D.	
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS CRISFIELD, MARYLAND		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 1, 1962	
23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR DATE FEB 5 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

2010

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
SOMERSET MARYLAND		a. STATE	b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b					
CRISFIELD LIFETIME		39					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS					
AT HOME		Johnson Creek Road					
3. NAME OF DECEASED (Type or print)		First	Middle				
Mary		B	E				
4. SEX	5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
FEMALE	WHITE			JAN 4-1872	90 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED		RETIRED		MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
LORENZO NELSON		HARRIETT LAWSON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				MRS MILFORD THORNTON		CRISFIELD - MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 2 yrs.							
429 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis 3 yrs.							
DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1962 , to January 7, 1962 , that I last saw the deceased alive on January 6, 1962 , and that death occurred at 5 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 33 W. Main St. Crisfield, Md					
ACTUAL SIGNATURE Sarah M. Peyton		DATE SIGNED 1/8/62					
PHYSICIAN'S NAME (Type) Sarah M. Peyton							
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
Cremation 1-9-62				ASBURY METHODIST		CRISFIELD MD	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
George Thornton Crisfield				DATE JAN 11 '62		Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01144

01132

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN lb X CRISFIELD , d. STREET ADDRESS RFD #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EDW. W. McCREADY MEMO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CAMDEN	Middle R	Last BRITTON
4. DATE OF DEATH	Month JANUARY	Day 19	Year 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 11, 1888
8. AGE (In years last birthday) 73 yrs.	9. IF UNDER 1 YEAR Months 0 Days 0	10. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Gas & Fuel Oil	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM BRITTON		14. MOTHER'S MAIDEN NAME MOLLIE Dize	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 216-05-3765 17. INFORMANT GLADYS BRITTON, CRISFIELD, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3 days -	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 493X		Pneumonia,	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Nemic searies, right.			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from..... saw the deceased alive on..... and that death occurred at.....		19 1-19-62 19....., that (I) (we) last 4:55 AM....., from the causes and on the date stated above.	
22e. SIGNATURE C. G. Rawley		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D.		22d. ADDRESS CRISFIELD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 21, 1962	23c. NAME OF CEMETERY OR CREMATORIAL American Legion Cemetery
23d. LOCATION (City, town or county) Crisfield, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		25a. REC'D BY REGISTRAR DATE JAN 25 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Trahan

3310

M

Q - FORT DODGE

RECEIVED

5-22-1942

RECORDED - INDEXED - SERIALIZED - FILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01145

CERTIFICATE OF DEATH

01133

1. PLACE OF DEATH
a. COUNTY

SOMERSET MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Crisfield

c. LENGTH OF STAY IN 16
35 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First LEAH

Middle S.

Last Brown

4. DATE
OF
DEATH

Month Jan.

Day 21 Year 1962

5. SEX

F

6. COLOR OR RACE

Negro

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

April 22, 1892

9. AGE (In years
last birthday)

69 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Pocomoke Md

U.S.

13. FATHER'S NAME

GEORGE Wheatton

14. MOTHER'S MAIDEN NAME

LEAH Wheatton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

215046533

17. INFORMANT

Rosie S. Brown P.O. Box 444

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

331X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last,

DUE TO

(b)

DUE TO

(c)

Cerebral hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

5 day

0 MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour e.m. 20d. INJURY OCCURRED While Not While p.m. et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

19

21. I certify that (I) (this hospital) attended the deceased from Jan. 17, 1962 to Jan. 23, 1962 that (I) (we) last saw the deceased alive on Jan. 21, 1962 and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Sarah M. Peyton M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. DATE SIGNED Jan. 23, 1962

22c. PHYSICIAN'S NAME (Type)

Sarah M. Peyton 22d. ADDRESS Crisfield Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF JAN. 28, 1962

23c. NAME OF CEMETERY OR CREMATORIUM CHANCE

24. FUNERAL DIRECTOR'S SIGNATURE

Anthony E. Howard Crisfield Md.

23d. LOCATION (City, town or county) (State)

Chance Md.

(State)

25a. REC'D BY REGISTRAR

JAN 26 '62

25b. REGISTRAR'S SIGNATURE

Charles S. House

M

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01134

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Marion		b. COUNTY Somerset	
c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Marion	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (Rural) Marion		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Fanny		First Schofield	Middle Cole
4. DATE OF DEATH Jan. 15 1962	Month Jan.	Day 15	Year 1962
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1899
9. AGE (In years last birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Seafood	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Clarence Schofield	14. MOTHER'S MAIDEN NAME Henrietta Selby	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service) No	
16. SOCIAL SECURITY NO. 220017166	17. INFORMANT Hattie B. Cole	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a.m. p.m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE C. G. Rawley		
EXAMINER'S NAME (Type) C. G. Rawley	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Crisfield, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/21/62	22c. NAME OF CEMETERY OR CREMATORIUM St. James Cemetery	22d. LOCATION (City, town, or county) Pocomoke
23. FINANCIAL DIRECTOR Anthony E. Ward Home	ADDRESS Crisfield, Md.	24a. REC'D BY REGISTRAR JAN 22 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Phane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01147				01135	
1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Maryland Ave.				d. STREET ADDRESS 112 Maryland Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First EUNICE	Middle —	Last EVANS	4. DATE OF DEATH Month January	Day 26 Year 1962
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1867	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Augustus Ward		14. MOTHER'S MAIDEN NAME Mary W. Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Charles R. Evans, 112 Maryland, Crisfield, Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 1 year					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) Arteriosclerosis Heart Disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 10 , 1962, to 26 , 1962, at 1 P.M. , from the causes and on the date stated above.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 , 1962, to 26 , 1962, that (I) (we) last saw the deceased alive on June 26 1962 , and that death occurred at 1 P.M. from the causes and on the date stated above.		22a. SIGNATURE Sarah M. Peyton		22b. DATE SIGNED 26 Feb 1962	
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS 33 W. Main St., Crisfield, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/62		23c. NAME OF CEMETERY OR CREMATORIAL Crisfield Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 5 1962	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01148

01136

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND c. LENGTH OF STAY IN 1b 6 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RUMBLEY (Frenchtown)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EDW. W. McCREADY MEMORIAL HOSP.		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF SUSIE (Type or print)	First J.	Middle FRENCH	Lesl	4. DATE OF DEATH JANUARY 24 1962	Month Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 4, 1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME THOMAS FORD		14. MOTHER'S MAIDEN NAME Ella Parks		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. CAROL FRENCH, RUMBLEY, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 984 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Chronic & long-standing condition		DUE TO (b) Chronic & long-standing condition		INTERVAL BETWEEN ONSET AND DEATH 6 days	
DUE TO (c) From P.H.L.					
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Precipitated by severe pain					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Jan 18, 1962, fall		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 1-18 62	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) French Private Cemetery	20f. (City or town) MARION, MARYLAND	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1962 to 1-24-62 , 1962, that (I) (we) last saw the deceased alive on 1-23-62 , 1962, and that death occurred at 1:05 AM on the causes and on the date stated above.	22b. DATE SIGNED 1/24/62				
22c. SIGNATURE George C. Coulbourn, M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.	22d. ADDRESS MARION, MARYLAND				
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 1/26/62	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS French Private Cemetery		23d. LOCATION (City, town or county) Frenchtown, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland	25a. REC'D BY REGISTRAR DATE JAN 29 '62				
	25b. REGISTRAR'S SIGNATURE John S. Kraus				



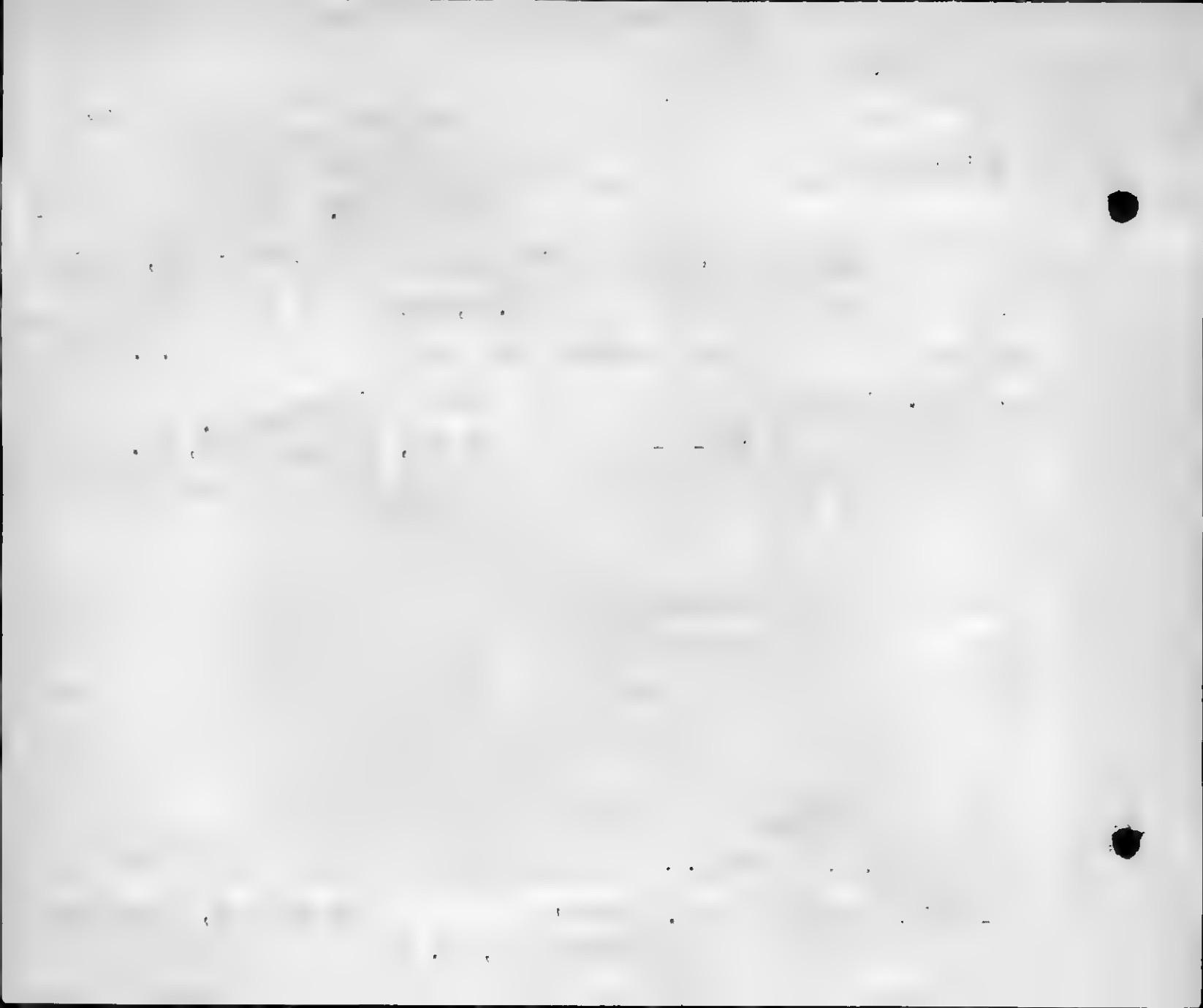
1
FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
01149					01157					
1. PLACE OF DEATH a. COUNTY		MARYLAND								
Somerset		c. LENGTH OF STAY IN lb								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
Princess Anne		Princess Anne								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS								
Beechwood St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Charles James Gibbons					January 19,	1962				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 19, 1876	85	Months	Days	Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)						
Retired		Feed Company		Maryland						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
John E. Gibbons		Hester Gibbons								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT						
				213-01-8881 John Gibbons, Princess Anne, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Coronary Heart Disease (Died in his sleep)								
420.1		DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)								
		DUE TO								
		(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
ACTUAL SIGNATURE <i>R. H. Johnson, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
EXAMINER'S NAME (Type)		DATE SIGNED 1/19/62								
R. H. Johnson, M.D.		Address (Street, city, town, or county) Princess Anne, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/21/62	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Andrew's Princess Anne, Md.							
Burial		22d. LOCATION (City, town, or country) (State)	24a. REC'D BY REGISTRAR Princess Anne, Maryland JAN 22 '62 24b. REGISTRAR'S SIGNATURE <i>A. L. Turner</i>							
23. FUNERAL DIRECTOR <i>Jones Funeral Home</i>										
VS. ATISME SM 9 60										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

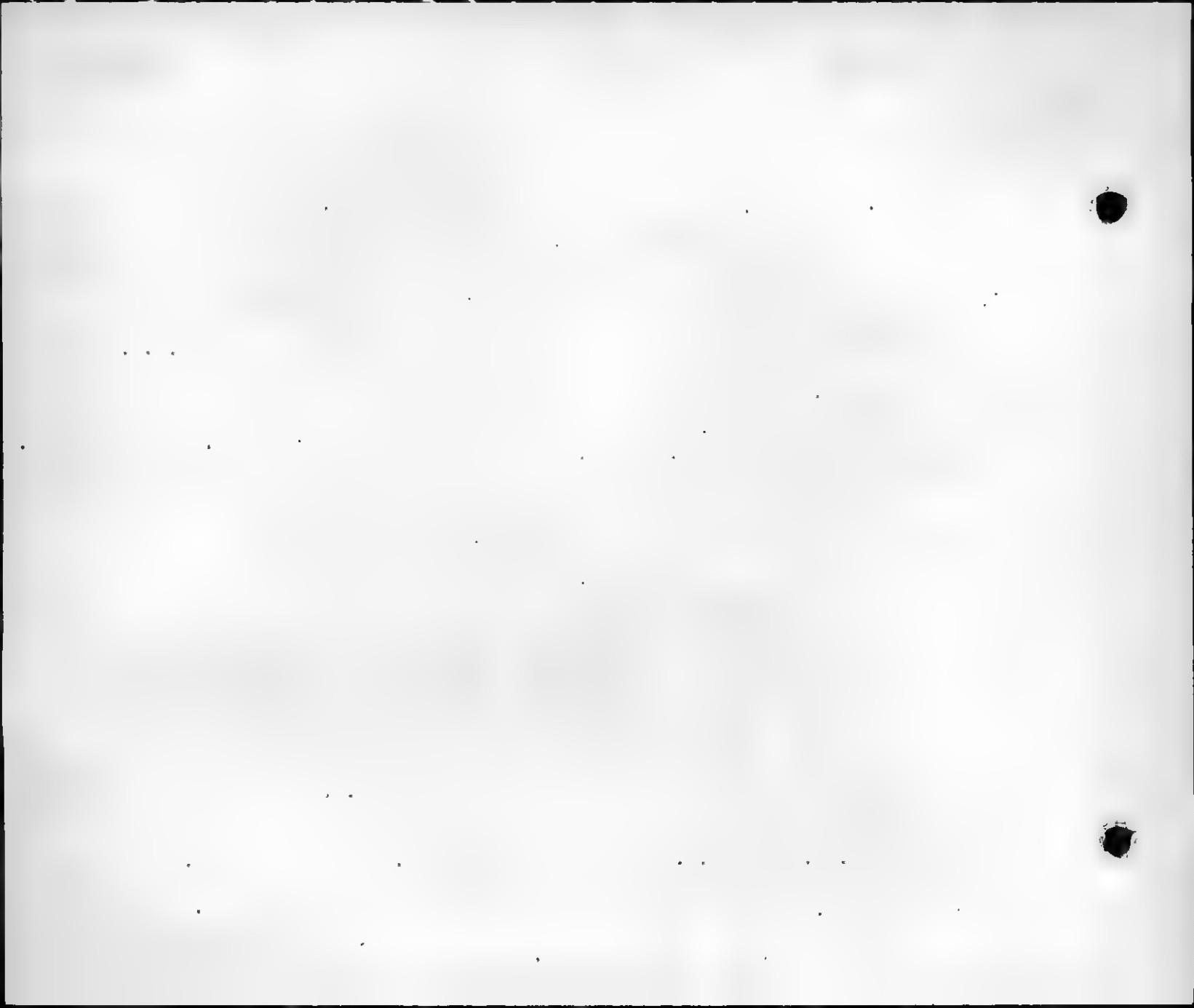
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01150

CERTIFICATE OF DEATH

02345

1. PLACE OF DEATH a. COUNTY Somerset		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Columbia Ave.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
3. NAME OF DECEASED (Type or print) ELIA KELLY GOLDSBOROUGH		First Middle Last		4. DATE OF DEATH January 30 1962		Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 17, 1879		9. AGE (In years last birthday) 82 yrs.	
								IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Chance, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah T. Kelly				14. MOTHER'S MAIDEN NAME Roxanna Parks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John Goldsborough--Somerset Ave.--Crisfield, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493 X		DUE TO Topic Myocarditis						10 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Terminal Pneumonia						2 days	
(c) Feline Degeneration									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 10:50 P.M.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/21 1953 to 1/30 1962 that (I) (we) last saw the deceased alive on 1/30 1962 , and that death occurred at M. from the causes and on the date stated above									
22a. SIGNATURE A. N. Barr, M.D.		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10:50 P.M.			
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		22d. ADDRESS Main St. -- Crisfield, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 2, 1962		23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery		23d. LOCATION (City, town, or county) Crisfield, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE 4 8 '62		25b. REGISTRAR'S SIGNATURE John S. Lewis			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01151

CERTIFICATE OF DEATH

01158

1. PLACE OF DEATH
a. COUNTYM
SOMERSET

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

CRISFIELD

c. LENGTH OF STAY IN 1b

28 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

E.W. MCCREADY MEMORIAL HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First MIDDLE

CLIFTON

Last GREEN

4. DATE
OF
DEATH JANUARY 16
Month Day Year
1962

5. SEX

M

6. COLOR OR RACE

NEGRO

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

7-20-1907

9. AGE (In years
last birthday)

54 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SEAFOOD WORKER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

JOHN GREEN

14. MOTHER'S MAIDEN NAME

TEENY JOYNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

CRISFIELD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)420.1 DUE TO
Conditions, if any, which
gave rise to immediate causa
(a), stating the underlying
cause last.
(b)
DUE TO
(c)

coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

28 days

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 12 - 19, 1961 to JAN 16, 1962 that (I) (we) last saw the deceased alive on JAN 16, 1962, and that death occurred at 5 A.M. from the causes and on the date stated above.

22a. SIGNATURE

C.R. Rawley

M.D.

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS. 22b. DATE
SIGNED
JAN 16, 196222c. PHYSICIAN'S
NAME (Type)

C.G. RAWLEY, M.D.

22d. ADDRESS

CRISFIELD, MARYLAND

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial 12 Jan 62

23c. NAME OF CEMETERY OR CREMATORIUM

Asbury

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

H. McCready, Jr.

ADDRESS

111 S. 4th St.

CRISFIELD MD.

25a. REC'D BY REGISTRAR

DATE JAN 22 '62

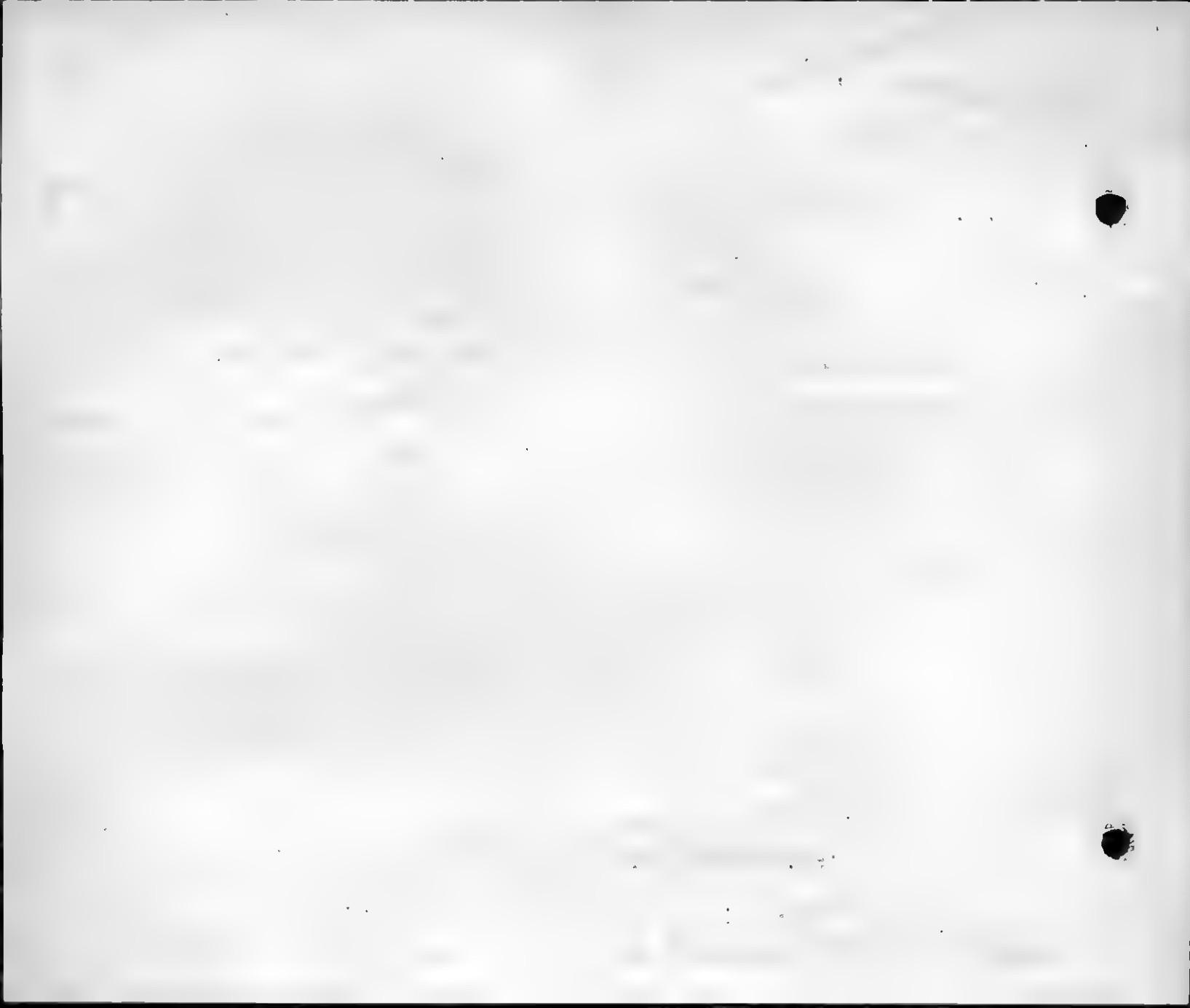
25b. REGISTRAR'S SIGNATURE

John S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01152

CERTIFICATE OF DEATH

Reg. Dist. No.

02348

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 113 S 4TH ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RACHEL		First	Middle	Last	4. DATE OF DEATH JAN 30 1962
5. SEX F	6. COLOR OR RACE Negro	7. <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH MAY 16, 1873	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Thomas Brinkley		14. MOTHER'S MAIDEN NAME Sarah Sterling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 712-16-121911		17. INFORMANT SARAH MILES 424 Port Norris N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Tropic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH One Day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Central Vascular Accidents		DUE TO 5 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sensitivity. Inanition		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CRISFIELD, MARYLAND	
20f. (City or town) CRISFIELD, MARYLAND		(County) Md.		(State) MARYLAND	
21. I certify that I attended the deceased from Jan 25, 1962 to Jan 30, 1962 , that I last saw the deceased alive on Jan 29, 1962 , and that death occurred at 4:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND					
DATE SIGNED 5/3/62					
ACTUAL SIGNATURE A. N. BRINKLEY, M.D.					
PHYSICIAN'S NAME (Type) A. N. BRINKLEY, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 4, 1962		22c. NAME OF CEMETERY OR CREMATORIAL ASBURY	
22d. LOCATION (City, town, or county) LAWSONTON		(State) MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Anthony E. Ward CRISFIELD MD		24a. REC'D BY REGISTRAR DATE FEB 8 '62		24b. REGISTRAR'S SIGNATURE 1. S. H. MARSHALL	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01153

Item 8 Form 3-55 1/25/62 iwk

CERTIFICATE OF DEATH

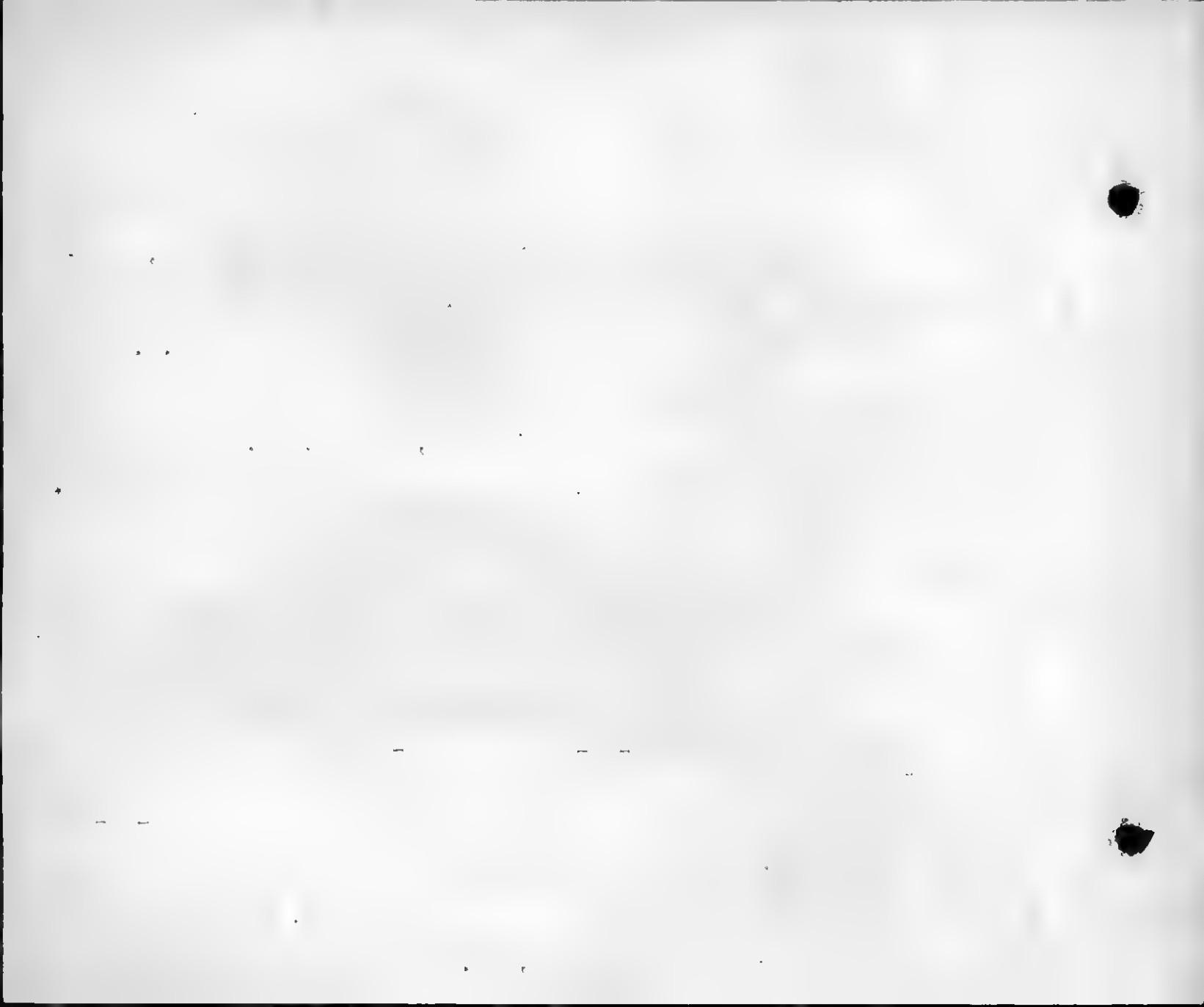
Reg. Dist. No.

01153

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First William	Middle Clarence
		Last Muir	4. DATE OF DEATH January 16, 1962
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1892
		WIDOWED <input type="checkbox"/>	8. AGE (In years lost birthday) 69 yrs.
		DIVORCED <input type="checkbox"/>	9. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward Muir		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mattie Muir, Oriole, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c) coronary arteriosclerosis		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) upper respiratory infection 2 days duration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15-62 , 19, to 1-16-62 , 19, that I last saw the deceased alive on 1-15-62 , 19, and that death occurred at 3A M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Everett C. Sutter</i> PHYSICIAN'S NAME (Type) Everett C. Sutter MD		ADDRESS (Street, city or town, state) Dames Quarter, Maryland 1-17-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/62	
22c. NAME OF CEMETERY OR CREMATORIAL Oriole		22d. LOCATION (City, town, or county) (State) Oriole, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James P. Johnson</i>		24a. REC'D BY REGISTRAR DATE JAN 22 '62	
		24b. REGISTRAR'S SIGNATURE <i>L. L. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01154

CERTIFICATE OF DEATH

Reg. Dist. No. 01154

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Somerset						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Crisfield		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Crisfield		d. STREET ADDRESS Asbury Ave.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Layton	Middle E.	lost Powell	4. DATE OF DEATH January 11, 1962	Month January	Day 11	Year 1962				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 25, 1893	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS Days 0	Hours 0	Min 0				
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Pa. Railroad		10b. KIND OF BUSINESS OR INDUSTRY Utility		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.						
13. FATHER'S NAME Littleton Powell		14. MOTHER'S MAIDEN NAME June Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		Address Mrs. Edna Powell, Asbury Ave, Crisfield,				
17. INFORMANT								Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema		DUE TO 525X		INTERVAL BETWEEN ONSET AND DEATH Unknown						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Myocardial Hypertrophy & Enlargement of Heart										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 345 P.M.	20f. (City or town) CRISFIELD, MD	(County) Hopewell, Maryland	(State) MD
21. I certify that I attended the deceased from Sept 1960 to Jan 11, 1962 , that I last saw the deceased alive on Jan 11, 1962 , and that death occurred at 345 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE A. N. Barr, M.D.		M.D.		ADDRESS (Street, city or town, state) CRISFIELD, MD		DATE SIGNED 1/13/62				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1962		22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge		22d. LOCATION (City, town, or county) Hopewell, Maryland		(State) MD				
23. FUNERAL DIRECTOR'S SIGNATURE James J. Penman		ADDRESS Crisfield, Md.		24a. REC'D BY REGISTRAR JAN 17 1962		24b. REGISTRAR'S SIGNATURE Charles L. Heath						

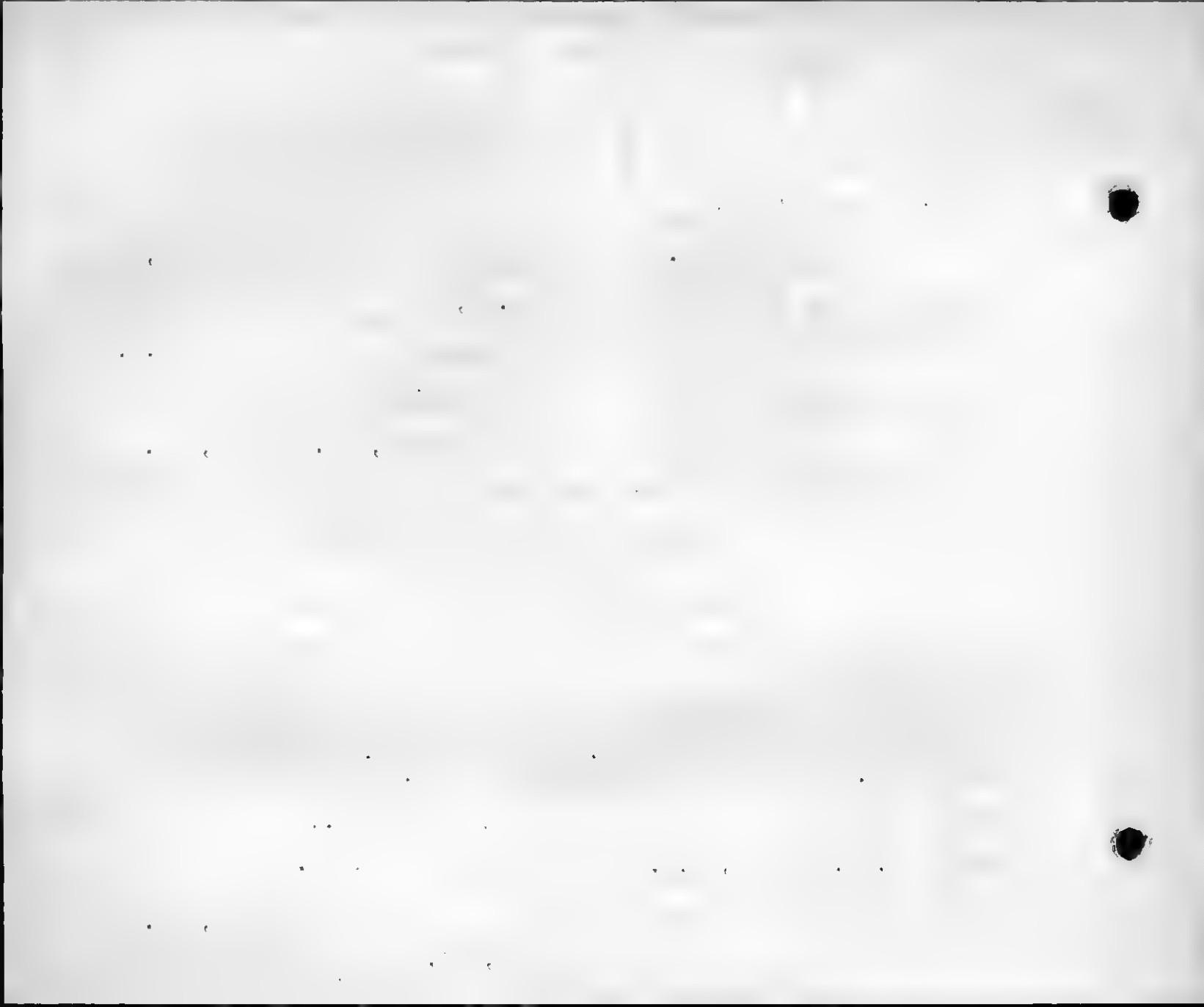


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11141

01155			
1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Menzel Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Minnie		First A.	Middle Simpkins
4. DATE OF DEATH January		Month 21,	Day Year 1962
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1883
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Levin Wallace		14. MOTHER'S MAIDEN NAME Hettie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Elwood Simpkins, Mt. Vernon, Md.	
17. INFORMANT Elwood Simpkins, Mt. Vernon, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>45</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 23, 1961 to Jan. 21, 1962 , that I last saw the deceased alive on Jan. 11, 1962 , and that death occurred at 3 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>C. G. Rawley</i> M.D. 324 Main St., DATE SIGNED 1/23/62	
PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.		Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/62	22c. NAME OF CEMETERY OR CREMATORIUM White Cemetery
22d. LOCATION (City, town, or county) Dames Quarter, Md.		(State)	
22e. FUNERAL DIRECTOR'S SIGNATURE <i>James Herman</i>		24a. REC'D BY REGISTRAR Princess Anne, Md.	24b. REGISTRAR'S SIGNATURE <i>J. J. F. 1/23/62</i>
VS A15 (4) 15M 10/57			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 14 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, part 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, parts 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

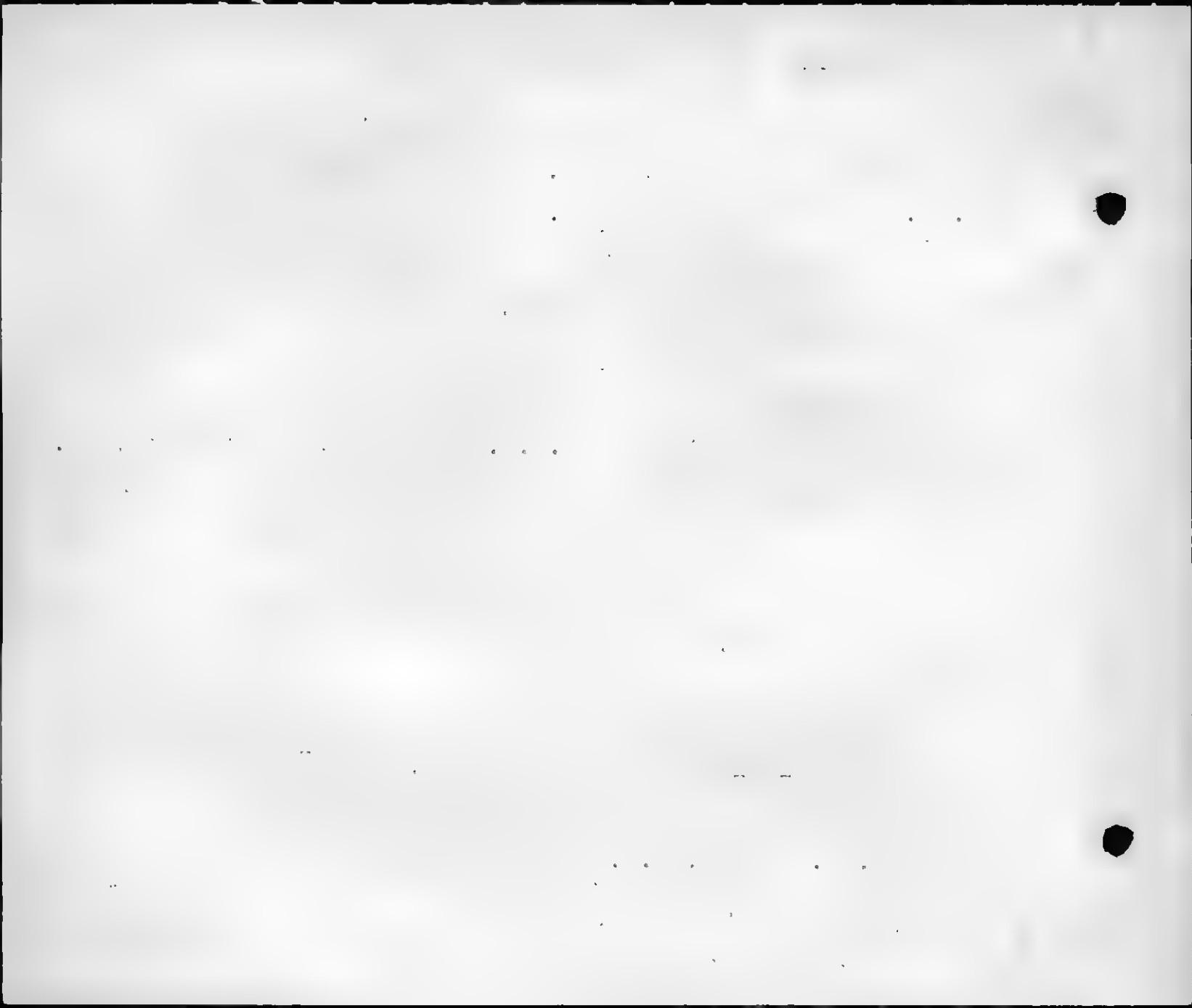
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01156

01142

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN lb 74 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EDW. W. McCREADY MEMORIAL HOSP.		e. STREET ADDRESS MAIN STREET	
3. NAME OF LENORA (Type or print)	First LENORA	Middle Sterling	Last TAWES
4. DATE OF DEATH JANUARY 16 1962	Month JANUARY	Day 16	Year 1962
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 16, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC STERLING		14. MOTHER'S MAIDEN NAME DOLLIE STERLING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> None		16. SOCIAL SECURITY NO. (It yes give war or date of service) None	
17. INFORMANT J.C.W. TAWES, JR., CRISFIELD, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pneumonia		18 hrs	
(b) DUE TO Pulmonary Embolus -		18 hrs	
(c) Senile Arterio sclerosis -		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1935 PM 1-16-62 , 19....., that (I) (we) last saw the deceased alive on 1-16-62 19....., and that death occurred at 3:50 PM 1-16-62 , 19....., M., from the causes and on the date stated above.			
22a. SIGNATURE C. G. Rawley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 18, 1962	
23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town or county) Crisfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		25a. REC'D BY REGISTRAR DATE JAN 22 1962	25b. REGISTRAR'S SIGNATURE C. G. Rawley



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

01157

01143

1. PLACE OF DEATH
a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Crisfield

c. LENGTH OF STAY IN TB

None

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Edw. W. McCready Reno., Hall Hwy.

3. NAME OF
DECESSED
(Type or print)

JAMES

ALFRED

TINGLE

4. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

7. MARRIED NEVER MARRIED WIDOWED D.VORCED

8. DATE OF BIRTH

Aug. 9, 1915

9. AGE (In years
last birthday)

46

yrs.

10. IF UNDERTAKER

Months

Days

11. F UNDER 24 HRS.

Hours

Min.

13. FATHER'S NAME

Arlie Tingle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

Unk own

16. SOCIAL SECURITY NO.

435184851

17. INFORMANT

McCready Hosp./

Mrs. Doris Tingle-(Wife)

Address-Cove St
Crisfield, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Self-inflicted bullet wound, head.

INTERVAL BETWEEN
ONSET AND DEATH

12 hrs.

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot self with revolver--suicide.

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. Jan. 8 196220d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
Street

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

C. G. Ravley

CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DATE SIGNED
1/9/62EXAMINER'S
NAME (Type)

C. G. Ravley, M.D.

Address (Street, city, town, or county) Crisfield, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF Jan. 12, 1962

22c. NAME OF CEMETERY OR CREMATORIAL
Presbyterian Cemetery

22d. LOCATION (City, town, or country) Princess Anne, Maryland

(State)

23. FUNERAL DIRECTOR

Holloway & Co. -- Salisbury, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

DATE JAN 15 '62

24b. REGISTRAR'S SIGNATURE

C. G. Ravley

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit Permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT SME
5M 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reported by the hospital or attending physician.

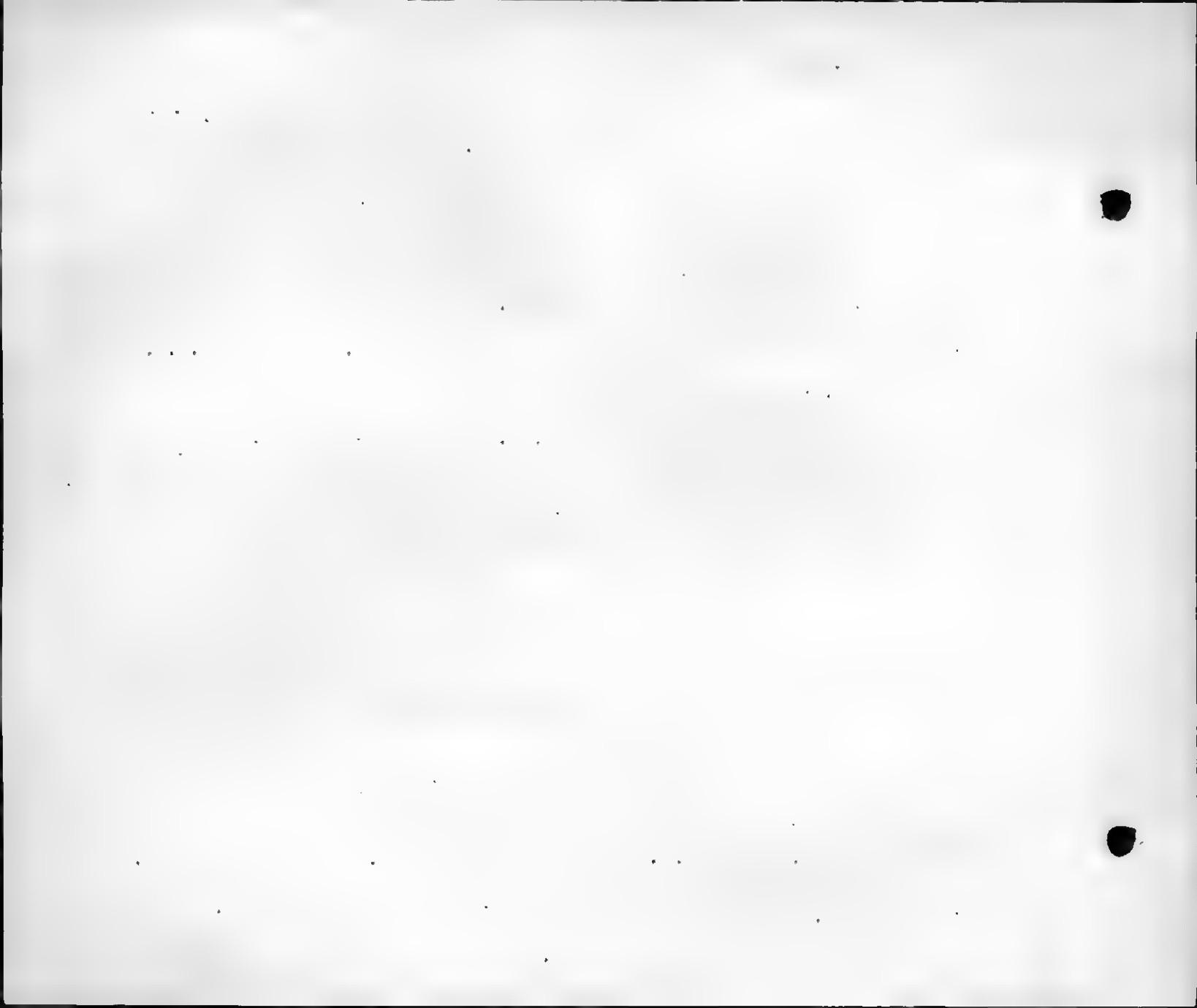
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01144

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crisfield				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jacksonville Section				d. STREET ADDRESS Jacksonville Section		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) HERBERT LEE TULL		First	Middle	Last	4. DATE OF DEATH January 21, 1962	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1888	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Seafood Packing		11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Tull				14. MOTHER'S MAIDEN NAME Susan Payne				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Rev. W. Edwin Tull--Milford, Delaware		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH DUE TO 420.1 minutes								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO		Coronary Artery Disease		3 hr.		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crisfield (County) Wicomico Co. (State) Md.		
21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1961 to Jan. 21, 1962 that (I) (we) last saw the deceased alive on Jan. 16, 1962 and that death occurred at 6:30 P.M. from the causes and on the date stated above.								
22a. SIGNATURE Sarah M. Peyton		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED Jan. 29, 1962	
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M.D.		22d. ADDRESS Main St. -- Crisfield, Md.						
23a. BURIAL, CREMAT. ON. REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 24, 1962		23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town, or county) Crisfield, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 29 '62		25b. REGISTRAR'S SIGNATURE ✓ E. Bradshaw		



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01145

1. PLACE OF DEATH

a. COUNTY

Somerset

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

(Rural) Marion

c. LENGTH OF STAY IN lb

MARYLAND

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

(Rural) Marion

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
Jan.

Dey
28

Year
1962

5. SEX

6. COLOR OR RACE

Male

Negro

10a. US/JAI OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

13. FATHER'S NAME

John Wesley Waters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
instant-
aneous

MEDICAL CERTIFICATION

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20c. TIME OF INJURY Month, Dey, Year
Hour o.m.
p.m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED
1/30/62

Crisfield, Md.
(State)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

Burial Feb. 1, 1962

Unionville Cemetery

Pocomoke

Md.

23. FUNERAL DIRECTOR

Wharton & Savage

ADDRESS

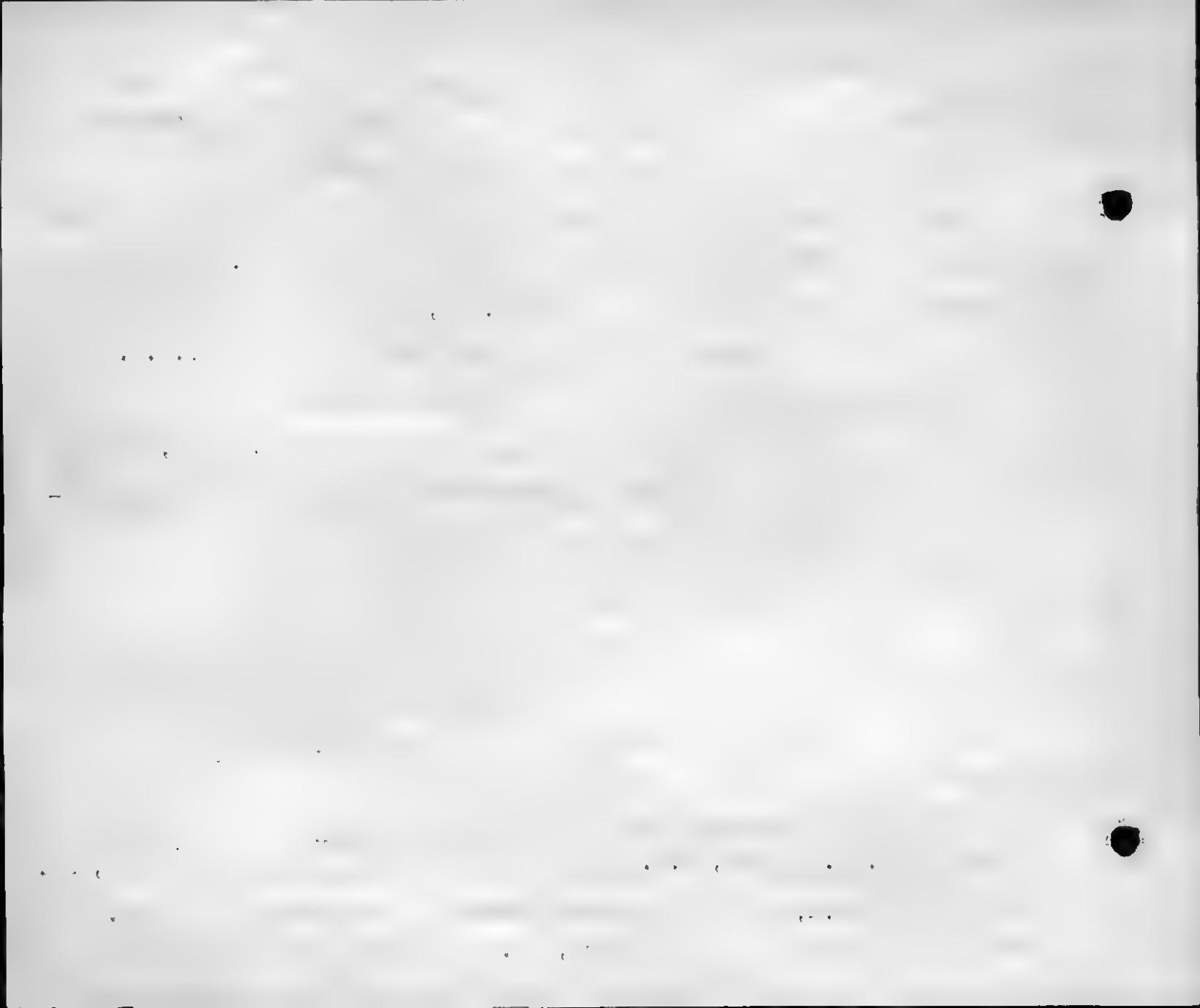
New Church, Va.

24e. REC'D BY REG. STRR 24b. REGISTRAR'S SIGNATURE

FEB 5 '62

Clifford L. Evans

VS. A15ME
SM 7/59

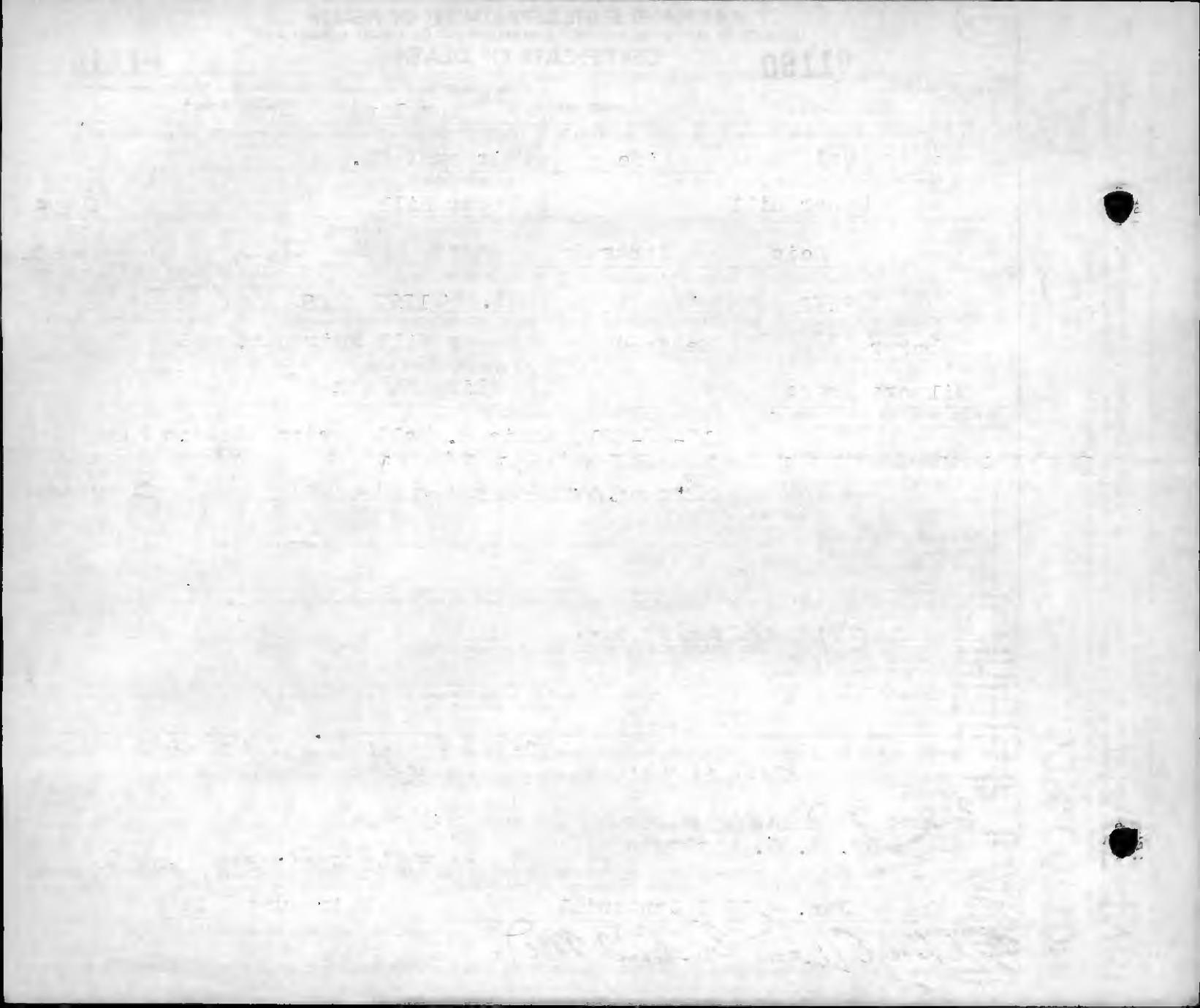


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01150

01146

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount MD. X							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Upper Hill			d. STREET ADDRESS Upper Hill							
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Lois	Middle Gertrude	Last Waters	4. DATE OF DEATH	Month Jan	Day 1	Year 1962		
S. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 24 1893	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Seafood			11. BIRTHPLACE (State or foreign country) Upper Hill Fairmount				
13. FATHER'S NAME Wilmore Boggs			14. MOTHER'S MAIDEN NAME Eliza Maddox							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-03-0813			17. INFORMANT Annie E. Bell Marion Station MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Brancho Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
49/X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)										
DUE TO (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 24 1961 to Jan. 19 1962 that (I) (we) last saw the deceased alive on Dec. 31 1961, and that death occurred at 103rd St. from the causes and on the date stated above.									22b. DATE SIGNED	
22a. SIGNATURE E. G. Marksman			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) Dr. E. G. Marksman			22d. ADDRESS Princess Anne, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4 1961		23c. NAME OF CEMETERY OR CREMATORIAL Centennial		23d. LOCATION (City, town, or county) Fairmount MD			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE H. L. Marksman, Funeral Director, MD.			ADDRESS			25a. REC'D BY REGISTRAR DATE Jan 4 '62		25b. REGISTRAR'S SIGNATURE S. L. Marksman		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01147

1. PLACE OF DEATH a. COUNTY <i>Somersett</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Somerset</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hope Well</i>		c. LENGTH OF STAY IN 1b <i>Life Time</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Dames Quarter</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Johnson Nursing Home</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Major</i>	Middle <i>L</i>	Last <i>White</i>	4. DATE OF DEATH	Month <i>I</i>	Day <i>4</i>	Year <i>1962</i>
5. SEX	6. COLOR OR RACE <i>Male Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/23/1882</i>	9. AGE (In years last birthday) <i>79</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. White</i>		14. MOTHER'S MAIDEN NAME <i>Mary G. White</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>George W. White II, Dames Quarter, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis with left hemiplegia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Generalized arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i> (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input type="checkbox"/> NO <input type="checkbox"/>							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>324 Main St., Crisfield, Md</i>	(County) <i>Wicomico Co.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Aug. 21, 1961</i> , to <i>Jan. 4, 1962</i> , that I last saw the deceased alive on <i>Jan. 4, 1962</i> , and that death occurred at <i>9:30 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>324 Main St., Crisfield, Md</i> DATE SIGNED <i>1/6/62</i>							
ACTUAL SIGNATURE <i>C. G. Rawley</i>	PHYSICIAN'S NAME (Type) <i>C. G. Rawley, M.D.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/7/1962</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Macedonia</i>	22d. LOCATION (City, town, or county) (State) <i>Dames Quarter, Maryland</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. James Jr., Princess Anne, Md</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JAN 8 '62</i>	24b. REGISTRAR'S SIGNATURE <i>John J. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 2010 RELEASE UNDER E.O. 14176 - APPROXIMATELY 10% OF THE ORIGINAL DOCUMENT IS REDACTED